Clear entire form

MH555
Revised 3/03

# ADULT SUBSTANCE USE SELF EVALUATION

Date Completed: _____ Date of Birth: _____ Sex: ☐ F ☐ M

**During the past 12 months :**

1. Have you ever felt that you use too much alcohol or other drugs? ☐ YES ☐ NO
2. Have you tried to cut down or quit drinking or using drugs? ☐ YES ☐ NO
3. Have you gone to anyone for help because of your drinking or drug use? (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) ☐ YES ☐ NO
4. Have you had any of the following: ☐ YES ☐ NO
   - Blackouts or other periods of memory loss due to substance use
   - Injury to your head after drinking or using drugs
   - Convulsions or delirium tremens ("DTs")
   - Hepatitis or other liver problems
   - Feeling sick, shaky, or depressed when you stopped drinking or using drugs
   - Feeling "coke bugs," or a crawling feeling under the skin, after you stopped using drugs
   - Injury after drinking or using drugs
   - Using needles to shoot drugs
5. Has drinking or other drug use caused problems between you and your family or friends? ☐ YES ☐ NO
6. Has your drinking or other drug use caused problems at school or at work? ☐ YES ☐ NO
7. Have you been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) ☐ YES ☐ NO
8. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? ☐ YES ☐ NO
9. Are you needing to drink or use drugs more and more to get the effect you want? ☐ YES ☐ NO
10. Do you spend a lot of time thinking about or trying to get alcohol or drugs? ☐ YES ☐ NO
11. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? ☐ YES ☐ NO
12. Do you feel bad or guilty about your drinking or drug use? ☐ YES ☐ NO

**During your lifetime:**

1. Have you ever had a drinking or other drug problem? ☐ YES ☐ NO
2. Have any of your family members ever had a drinking or drug problem? ☐ YES ☐ NO
3. Do you feel you have a drinking or drug problem now? ☐ YES ☐ NO



**Name:** _____ **MIS#:** _____

**Agency:** _____ **Prov#:** _____

**Los Angeles County - Department of Mental Health**

ADULT SUBSTANCE USE SELF EVALUATION